STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BENEFICIARY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY SERVICES
201 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201

MANUAL: Medical Assistance

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APPLICABILITY: E-track for children in foster care or subsidized adoptions, T-track for children or TCA adults in long-term care facilities, emergency medical services for illegal/ineligible aliens, revised DES 401, trusts, verification requirements, Women's Breast and Cervical Cancer

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Policy Alert 03-10 "Children and TCA Adults in Long-Term Care Facilities" (T-track)		Policy Alert 03-10 (after Policy Alert 03-9)
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COMMENTS

- Policy Alert 03-8 about Medical Assistance (MA) eligibility determinations for children in State out-of-home placements (E-track) is revised to specify that retroactive eligibility should be determined upon request. The policies about retroactive eligibility in COMAR 10.09.24.04 and 09 and Chapters 4 and 9 of the MA Eligibility Manual apply to the E-track as with other MA coverage groups. If an applicant has unpaid medical bills, the applicant or authorized representative may request at any time during the 6-month period under consideration that retroactive eligibility be determined for the 3 months prior to the month of application. If the applicant does not meet the E-track's eligibility requirements in the retroactive period, retroactive eligibility is determined for whatever coverage group the applicant may qualify (F, G, P, or S track).

- Policy Alert 03-10 presents MA eligibility policies and procedures for the T-track, covering children institutionalized in long-term care facilities. Also, coverage group T01 is used for adult recipients of Temporary Cash Assistance (TCA) who are institutionalized.

- In the section of Chapter 4 about verification requirements, the circumstances are specified for when a declaration of information may be accepted for an initial application if there is a confirmed impediment to obtaining a required verification in a timely fashion.

- Certain requirements are revised in Chapter 5 related to eligibility determinations for the X02 coverage group—emergency medical services for illegal or ineligible aliens. If the alien is being considered for X02 eligibility as a disabled adult, a disability determination by the State Review Team must be included in the paperwork sent to the Department of Health and Mental Hygiene (DHMH) for the medical eligibility review. The DES 401 form, "Emergency Services to Ineligible Aliens," is also revised with this change.

- Chapter 8 is revised related to trusts. When determining whether a trust is countable for MA as a resource of the owner, whose funds went into the trust are not considered. However, this information is used when determining whether a penalty period is necessary due to disposal of income or resources for less than fair market value.

- Effective June 9, 2003, COMAR 10.09.24.03-1 was amended for the MA coverage group for Women with Breast or Cervical Cancer (W01). Instead of women being ineligible for MA under this coverage group if they are enrolled in both Medicare Part A and Part B, they are excluded, in accordance with federal requirements, if they are enrolled in either Medicare Part A or Part B.

Policy Alert 03-8
Children in State Out-of-Home Placements – Medicaid Eligibility Determination Eligibility Policies and CARES Procedures
Effective: Upon Receipt for New E-Track Applications
At Redetermination for Existing E-Track Cases

Summary:

The Centers for Medicare and Medicaid Services approved changes in Medical Assistance (Medicaid or MA) eligibility requirements for E-track children in out-of-home placements (OHP). **Income and resources are no longer a factor of MA eligibility for foster care or subsidized adoption children in the E-track.** Therefore, the only reason for a foster care child to be MA eligible in the State-only coverage group of E03 is if the child fails a technical factor of MA eligibility, such as citizenship or Social Security number (SSN). Non-IV-E eligible children in State subsidized adoptions are eligible in the federal category of E02 if they meet MA technical eligibility requirements and have special needs for medical, mental health, or rehabilitative care. E01 is for IV-E or SSI eligible foster care or subsidized adoption children. E02 is for non-IV-E foster care children or special needs subsidized adoption children who are not IV-E or SSI eligible, but meet the MA technical eligibility requirements. The State-only category of E03 is for all other children in State foster care; and the State-only category of E04 is for all other children in State subsidized adoptions.

When the State places a child in foster care or subsidized adoption, it is imperative that the MA certification process is timely so that the child has immediate access to health care coverage. **If there are unpaid medical bills for the child, retroactive eligibility should be determined for the 3 months prior to the date of MA E-track application.** Good communication between the OHP service worker, FIA MA case manager, and IV-E specialist (who determines IV-E eligibility) at the local department of social services (LDSS) is necessary to ensure prompt and correct MA coverage.

This Policy Alert provides uniform procedures to be followed by all local offices when processing E-track MA applications filed on behalf of a child in OHP (IV-E or State foster care and subsidized adoptions) when:

- The child is filing an initial MA application and is not already active or pending in CARES for MA and/or other eligibility; or
- The child applicant is already a recipient in an active or pending assistance unit (AU), such as Temporary Cash Assistance (TCA), Food Stamps (FS), Supplemental Security Income (SSI), MA, or the Maryland Children's Health Program (MCHP).

Eligibility for OHP is established by the Department of Human Resources' regulations found in COMAR 07.02.11. Federal funding of OHP services is governed by Title IV-E of the Social Security Act.

The E-track is only for foster care children committed by the courts to the custody of the Department of Human Resources (DHR) and for children receiving subsidized adoption services from DHR. The MA application for a foster care child must clearly indicate if parental rights have been terminated, because this triggers a child support referral. The procedures in this Policy Alert are not applicable to children placed in foster care or adoption by private agencies or individuals, who should have their eligibility determined under the appropriate MA or MCHP coverage group other than the E-track. They are not eligible in the E-track. However, the E-track may include children who are dually committed to the custody

of DHR and the Department of Juvenile Services, so long as the child is receiving foster care or subsidized services from DHR.

As long as children in the Kinship Care Subsidized Guardianship Waiver Program remain under the State's custody, they stay MA eligible in their E-track coverage group. Once guardianship is granted and the service case is closed, children in the Kinship Care Subsidized Guardianship Waiver Program must have their eligibility determined in the appropriate MA or MCHP coverage group other than the E-track. They are no longer eligible in the E-track. FIA Action Transmittal 01-02 dated 8/7/2000 addresses how to redetermine eligibility when the guardianship through the Kinship Care Program goes into effect for children previously certified in the E-track.

I. Eligibility Policy - Coverage Groups in the E-Track for Children in State Out-of-Home Placements (Foster Care) or in Subsidized Adoptions.

Note: The MA case manager should not test for income or resources for any of the coverage groups in the E-track as a condition of MA eligibility, but should still test for technical MA eligibility. The MA case manager should enter $1 for the foster care or subsidized adoption income and enter any child support, SSI, or SSDI income with a valid value of "ON" ("other non-countable"). The MA case manager should narrate for each type of non-countable income that is entered and for any other of the child's reported income or resources of the child that are not counted for the E-track eligibility determination, but may be needed for a future application.

Following is a description of the basic MA eligibility requirements for each coverage group in the E-track:

- E01: IV-E or SSI Children in Foster Care or Subsidized Adoption
  Federally matched MA is automatically provided, without a separate test for MA eligibility, to any child receiving adoption or foster care benefits who is either eligible under Title IV-E of the Social Security Act or SSI-eligible. Since CARES has little programming for E01, **a case should only be pended in E01 if the MA case manager confirms (through SVES, SDX, or SOLQ) that the child is receiving SSI benefits or if IV-E eligibility is confirmed by the LDSS IV-E specialist**, not based on a presumption of SSI or IV-E eligibility.
  - If it is later found that an E02, E03, or E04 child is IV-E or SSI eligible, the MA case manager should "J" screen an existing E01 assistance unit (AU) or use "Add A Program" to establish an AU for the E01 coverage effective as of the 1st of the month after the MA case manager is notified of the IV-E or SSI eligibility. If a previous E01 AU is available, the MA case manager could "J" screen an existing E01 AU, if one was previously available.
  - OHP children who receive Supplemental Security Income (SSI) are included in E01, rather than in the S02 coverage group, even if they are not IV-E eligible. However, since CARES is programmed to deny an E01 application with SSI ("SI") income, the child's SSI income should be entered on the CARES UINC Screen with a valid value of "ON" for other non-countable income. The MA case manager should fully narrate in CARES. Note: CR 758 is obsolete, which stated that SSI children in OHP should remain in coverage group S02. (Note: This will also involve clean-up of any OHP cases in S02, needing to be converted to E01 after this Policy Alert takes effect.)

- E02: Non-IV-E Foster Care and Special Needs Subsidized Adoption

  Federally matched MA is provided to foster care children who are not IV-E eligible, but who do meet the MA technical eligibility criteria at COMAR 10.09.24.05 (Chapter V of the Medicaid Eligibility Manual), including the MA citizenship requirements. Non-IV-E children also qualify for E02 if they are receiving subsidized adoption services through the Department of Human Resources, have special needs for medical, mental health, or rehabilitative care, and meet the MA technical eligibility requirements. Since CARES is programmed to apply the same medically needy financial rules for this group as for F98, the MA case manager must assure that CARES does not deny an eligible OHP case for E02 due to failing financial eligibility criteria (see Section II).

- E03: State Funded Foster Care

  The State funds full MA coverage for foster care children who are not federally eligible for E01 or E02.

  - Since CARES does not trickle properly to E03 from E01 or E02, the MA case manager should use "Add A Program" or "J" screen an existing E03 AU and complete the eligibility process for an E03 AU if a foster care child is ineligible for E01 or E02. The MA case manager must assure that a foster care child is in the appropriate coverage group, and is only in E03 if MA technical eligibility criteria are not met (e.g., SSN, citizenship).
  - If it is later determined that the child is IV-E or SSI eligible, the MA case manager should "Add A Program" or "J" screen an existing E01 AU and complete the eligibility process for an **E01** AU.
  - If verifications later confirm that the non-IV-E foster care child meets the MA technical eligibility criteria in COMAR 10.09.24.05 (including citizenship requirements), the MA case manager should "Add A Program" or "J" screen an existing E02 AU and complete the eligibility process for an **E02** AU.

- E04: State Funded Subsidized Adoption

  The State funds full MA coverage for children in State subsidized adoptions who are not federally eligible for E01 or E02.

  - Since CARES does not trickle properly to E04 from E01 or E02, the MA case manager should "Add A Program" or "J" screen an existing E04 AU and complete the eligibility process for an E04 AU if a subsidized adoption child is ineligible for E01 or E02.
  - If it is later determined that the child is IV-E or SSI eligible, the MA case manager should "Add A Program" or "J" screen an existing E01 AU and complete the eligibility process for an **E01** AU.
  - If verifications later confirm that the non-IV-E subsidized adoptions child with special medical needs meets the MA technical eligibility criteria in COMAR 10.09.24.05 (including citizenship requirements), the MA case manager should "Add A Program" or "J" screen an existing E02 AU and complete the eligibility process for an **E02** AU.

II. CARES Procedures Followed by MA Case Managers for MA Eligibility Determinations in the E-Track.

A. Notification by the Service Worker and IV-E Specialist.

A service unit (SU), which shows the type of service for the child, is created for each child entering foster care, kinship care, or subsidized adoption. This is based on the demographics, service information, and proper enumeration provided by the service worker. Either the existing Client ID is matched or, if there is no existing Client ID, a new one is created for the child.

1. The service worker promptly advises the FIA MA case manager of a child in foster care or subsidized adoption who needs to be certified for E-track OHP MA eligibility. **The MA case manager is also informed if retroactive eligibility should be determined because there are unpaid medical bills for the child. The child's retroactive eligibility should be determined based on the child's living circumstances prior to the OHP application month (e.g., newborn abandoned in hospital, child living with parent(s) or caretaker relative, child in long-term care facility for less than a full calendar month).**
2. The service worker acts as the child's representative for purposes of filing the MA application. The service worker must provide all available information and verifications requested by the MA case manager, **including related to retroactive eligibility and unpaid medical bills.**
3. The IV-E specialist provides information to the MA case manager about the child's IV-E eligibility. The MA eligibility determination should not be delayed by the IV-E determination. If the child meets technical eligibility for MA and the IV-E specialist has not yet determined IV-E eligibility when the MA application is being processed and finalized, the MA case manager should pend the application under Medical Coverage group **E02** and complete the eligibility determination process. If the child is later determined to be IV-E eligible, the MA case manager should "Add A Program" or "J" screen an existing E01 AU and complete the eligibility process for an **E01** AU as of the 1st of the month after the MA case manager is notified by the IV-E specialist.

B. Screening and Pending the MA Case.

When the MA case manager is notified by the service worker of a foster care or subsidized adoption child requiring an OHP MA eligibility determination:

1. Perform an inquiry in CARES to research and determine if the child is a member of another AU as active, pending, closed, or denied. Because the service AU has already been opened by the service worker, these cases should already be known to CIS, and a match should be made to the client on the database. Make every effort to screen the child for an existing Client ID to prevent assigning multiple IDs. If more than one ID exists, refer to CARES Bulletin 98-17, Multiple Client IDs, for how to close the duplicate ID.

Note: When a child is adopted, there is usually a break with the old AU and Client ID number. The child may get a new Social Security number (SSN), also. Only if a complete break is not intended for the adopted child would the old SSN, AU, and Client ID be linked on CARES with the new identifiers.

2. Screen the child in the appropriate E-track coverage group, using **Option "J" on the AMEN** Screen in CARES.
   - Use **E01** only if it is confirmed that the child is IV-E or SSI eligible.
   - Use **E02** for all other foster care or subsidized adoption placements.

agency. The service worker will receive the MA card, HealthChoice enrollment materials (if E01 or E02), and all eligibility notices.

- Optional: On the **AUTH REP** screen, enter the service worker as the Authorized Representative, type "R2", so that the OHP service worker will receive the MA card, HealthChoice enrollment materials (if E01 or E02), and all eligibility notices.

- For a subsidized adoption AU:
  - On the **ADDR** screen, enter the child's adoptive home as the residential address.
  - Optional: On the **AUTH REP** screen, enter the adoptive parent as Authorized Representative, type "R2", so that the adoptive parent will receive the MA card, HealthChoice enrollment materials (if E01 or E02), and all eligibility notices.

6. Presently, CARES requires that any child in the E-track have either foster care or State subsidized adoption **income**. Due to this requirement, enter $1.00 on the UINC screen for such unearned income.

- Use income type "FC", "DA" or "DD" for coverage group E01.
- Use income type "SF" for E02 or E03.
- Use income type "SS" for E02 or E04.

Since income and resources are no longer a factor of MA eligibility for the E-track, enter no other countable income or resources for the child. Enter any child support, SSI, or SSDI income with a valid value of "ON" for other non-countable income, and fully narrate on both the NARR screen and the Remarks screen about the child's income and resources, which may be needed for a future application.

- CARES will deny any E-track AU once SSI ("SI") income is entered. Therefore, to change the coverage group of an SSI child from S02 to E01, the amount of SSI income must be coded as "ON" (other non-countable income) on the **UINC** screen. In addition, $1 of foster care income must be entered on the **UINC** screen to ensure the child's technical eligibility on CARES for E01. Code the $1 income as "FC" (IV-E foster care) and process the case.

Follow these procedures until you are notified that CARES has been modified.

D. Processing and Finalizing the Eligibility Determination.

Select options **"P" Process and "Q" Finalize**. Note that the eligibility tests for the E-track are different than the tests performed in other MA tracks, to facilitate prompt eligibility determinations. Please reference Sections II.C.2 and 6 of this Policy Alert, to assure that the appropriate living arrangements and income types are entered.

1. For **E01**, there are virtually no eligibility tests on CARES for MA eligibility. For that reason, a child must not be screened in this coverage group unless the child is **confirmed** as SSI or IV-E eligible. A child screened in this coverage group will not fail MA eligibility, but will be certified as federally eligible, if processed correctly with the correct corresponding valid values. Until modifications are made to CARES for E-track coverage groups, trickling should not occur.

2. For **E02**, CARES applies the same eligibility tests as for the FAC medically needy category F98, which are no longer applicable for E-track eligibility. This is why countable resources and income should not be entered for E02, except for $1 of foster care or subsidized adoption income. The MA case manager must assure that CARES does not deny an E02 AU for financial eligibility reasons. If CARES denies an E02 AU for MA technical eligibility reasons (e.g., SSN, citizenship), the MA case manager should "Add A Program" or "J" screen an existing AU for a State-only E03 AU for a foster care case or E04 AU for a subsidized adoption case.

3. If retroactive MA eligibility (for at most 3 months prior to the month of E-track application) is requested due to the child's unpaid medical bills, the MA case manager must obtain information from the OHP service worker about the child's living arrangements prior to the OHP application month. The coverage group used for determining retroactive eligibility is based on those living arrangements and other factors related to eligibility.

4. It is imperative that a child placed in foster care or subsidized adoption is certified as promptly as possible, and that there is no lapse of coverage when a child is removed from another AU to be opened in an E-track coverage group.

- It is optimal to remove the child from an active AU on one day and then to open eligibility in an E-track coverage on the following day, since two transactions (close/open) do not read over to MMIS through the interface on the same day. Check MMIS to make sure that the transactions took effect.
- All E-track applications must be finalized as soon as practicable, with or without complete verifications.
  - If IV-E eligibility has not yet been determined by the IV-E specialist, finalize the case in E02. If the child is not eligible for E02 due to MA technical eligibility requirements (e.g., verifications, SSN, citizenship), "Add A Program" or "J" screen an existing AU for the State-only category of E03 for a foster care case or E04 for a subsidized adoption case.
  - If there are any outstanding verifications, use the valid value of "OT" for "Other" so the E03 or E04 AU will process within the 30-day timeframe.
  - Create a 745 Alert to check on requested or outstanding verifications within a month if the child was not eligible for:
    - E01 because the IV-E specialist has not yet determined IV-E eligibility; or
    - E02 due to lack of verifications related to technical MA eligibility (e.g., SSN, citizenship).
- If verification is later received that will enable certification in the federally matched coverage group, do "Add A Program" or "J" screen an existing AU, close the original AU, and certify the child in either E01 (for SSI or IV-E foster care or subsidized adoptions) or E02 (for non-IV-E federally-eligible foster care or special needs subsidized adoption).

E. Post Eligibility Activity.

Once the MA eligibility is certified on CARES, there is an overnight electronic transfer of the MA data from CARES to MMIS at DHMH. There is also an electronic transfer of absent parent data from CARES to the DHR Child Support Enforcement Administration. The service worker provides information about the absent parents for establishment of child support via the Eligibility Determination Document (EDD) from

Policy Alert 03-10
Children and TCA Adults in Long-Term Care Facilities
Medicaid Eligibility Determinations - Eligibility Policies and CARES Procedures

Effective: **Upon Receipt for New T-Track Applications**
At Redetermination for Existing T-Track Cases

Summary:

The T-track for Family Long-Term Care (LTC) is used for Medical Assistance (MA) eligibility determinations for children and certain adults admitted to a long-term care facility (LTCF). The T-track is different than the L-track, which is for aged, blind, or disabled (ABD) children or adults in LTC. The T-track is for children and adults whose MA LTC eligibility is determined using the eligibility policy for:

- families and children (FAC) under COMAR 10.09.24 - Medical Assistance Eligibility; or
- children under COMAR 10.09.11 - Maryland Children's Health Program (MCHP), but not including MCHP coverage under Title XXI of the Social Security Act (coverage groups P13 and P14 and the D-track).

When a child (under 21 years old) is admitted to a LTCF, MA LTC eligibility is determined for the T-track. If the child is currently MA community eligible (E, F, G, H, or S track) or MCHP eligible (P-track), an unscheduled redetermination is necessary. If the child is not an active MA or MCHP recipient, an initial MA LTC eligibility determination is conducted. The L-track is only used for a child who is a recipient of Supplemental Security Income (SSI) or whose LTC eligibility is determined using ABD rules. All SSI recipients, adults or children, who have no other source of income, have their LTC eligibility determined for coverage group L01, so they are not subject to annual redeterminations (see Policy Alert 10-08).

When a child, parent, or caretaker relative, who is active in MA community coverage group F01 due to receipt of Temporary Cash Assistance (TCA), is admitted to a LTCF, MA LTC eligibility may be determined for the T-track coverage group T01. Then, the recipient does not have to be determined as aged, blind, or disabled in the L-track in order to be covered by MA for LTC services.

This Policy Alert provides uniform policies and procedures to be followed by all local offices when determining LTC eligibility in the T-track for a child or a TCA adult.

I. Eligibility Policy - Coverage Groups in the T-Track for Children or TCA Adults in Long-Term Care

Following is a description of the basic MA eligibility policy for the T-track. For all individuals being determined for T-track eligibility:

- Eligibility is determined by LTC MA case managers (CMs) at the local departments of social services (LDSSs). However, a Financial Agent or a MA CM at the Division of Eligibility Waiver Services (DEWS) determines MA LTC eligibility for seriously

mentally ill or emotionally disturbed children who are admitted to an Institution for Mental Disease (IMD), Regional Institute for Children and Adolescents (RICA), or Residential Treatment Center (RTC).

- The applicant/recipient (A/R) is considered as a household of one person, since the child is in an out-of-home placement.
- Children who are active in coverage group S02 for SSI recipients, or who are revealed by clearances using SVES/SDX/SOLQ to be receiving SSI, should have their LTC eligibility determined in coverage group L01 if they have no income besides SSI, the same as adult SSI recipients admitted to LTCFs. (See Policy Alert 10-8 Redetermination Procedures for SSI Recipients Entering Long Term Care.)
- The DHR/FIA CARES 9708 is used as the MA application form for a child A/R. If the A/R is considered an adult, the DHR/FIA CARES 9709 is used.
- As with the L-track, the T-track requires a DHMH 257 before MA LTC eligibility may be determined. The State's Utilization Control Agent must certify that the child needs the level of care provided by the LTCF.
- A child is considered institutionalized as of the 1st day of the first full calendar month in a LTCF. However, an adult is considered institutionalized as of the 30th consecutive day in a LTCF. A LTC stay is not considered to be interrupted by admission to an acute care hospital or by transfer to a different LTCF.
  Example: A child who is 10 years old and active in coverage group P08 enters a LTCF on 7/15. The child is in an acute hospital 8/2-8/8, then returns to the LTCF and is there as of the end of August. Eligibility is determined for T05. P08 eligibility ends as of 7/31. T05 eligibility and the LTC span begins as of 8/1.
- When a MA or MCHP recipient is admitted to the LTCF, the community-based eligibility continues and the services in the LTCF are paid until the recipient is considered to be institutionalized. Then, a MA LTC eligibility determination is necessary in order for MA to cover the LTC services. If the recipient is enrolled in HealthChoice when admitted to the LTCF, the Managed Care Organization (MCO) (or the Mental Hygiene Administration for recipients admitted to a Residential Treatment Center or other psychiatric facility) covers the authorized care in the LTCF while the recipient is considered a community MA or MCHP recipient.
- If a MA or MCHP community recipient is admitted to a LTCF for a less than 30-day stay, follow the procedures on page 900-23 of the Medical Assistance Eligibility Manual.
- If a MA or MCHP community recipient is covered by Medicare for skilled or chronic care in a LTCF, follow the policies and procedures on page 900-24 of the Medical Assistance Eligibility Manual, and use the DES 501 which follows page 900-28-1.
- The MA LTC post-eligibility policies and procedures related to spousal impoverishment and calculation of the available income towards the cost of care are applied to recipients determined eligible in the T-track. These policies and procedures are specified in Chapter 10 of the Medical Assistance Eligibility Manual and in COMAR 10.09.24.10 and 10-1.
- For recipients eligible in the T-track, MA pays the portion of the facility's cost of care that exceeds the recipient's available income, and also covers all other MA services for which the recipient qualifies.

Family Long-Term Care T-Track

T01 TCA Adult or Child in Long-Term Care

When a child or adult who receives TCA under TANF Section 1931 (F01 coverage group) is placed in a LTCF, MA will pay the cost of care in the facility and cover other MA services for which the recipient is eligible. The TCA financial and non-financial eligibility requirements are specified in COMAR 07.03.03 and the TCA Manual, established by the Department of Human Resources.

T02 FAC Long Term Care - Medically Needy

MA is provided for an unmarried child under 21 years old in a LTCF, if the child's resources do not exceed the medically needy resource standard (no more than $2,500 in countable resources, after subtracting exclusions) and if the child's countable net income (after subtracting exclusions and disregards) is insufficient to pay the LTCF's cost of care. These are the same LTC medically needy income and resource standards used for coverage group L98--ABD persons in LTC. However, the T02 coverage group uses the FAC rules in COMAR 10.09.24.07 and .08 and Chapters 7 and 8 of the Medical Assistance Eligibility Manual for the income and resource exclusions and the income disregards.

T03 Child Under 1 Year Old in Long Term Care

MA is provided for a child under 1 year old who resides in a LTCF. The financial and non-financial eligibility rules for P06 are used, as specified in COMAR 10.09.11 and the MCHP Eligibility Manual. The child's income must be at or below 185% of the federal poverty level (FPL). There is no resource test.

T04 Child From 1 Year Old Up to 6 Years Old in Long Term Care

MA is provided for a child who is at least 1 year old but less than 6 years old who resides in a LTCF. The financial and non-financial eligibility rules for P07 are used, as specified in COMAR 10.09.11 and the MCHP Eligibility Manual. The child's income must be at or below 133% of the FPL. There is no resource test.

T05 Child Under 19 Years Old in Long Term Care

MA is provided for a child under 19 years old who resides in a LTCF. The financial and non-financial eligibility rules for P08 are used, as specified in COMAR 10.09.11 and the MCHP Eligibility Manual. The child's income must be at or below 100% of the FPL. There is no resource test.

T99 FAC Long Term Care - Medically Needy Spenddown

Unmarried children under 21 years old in a LTCF whose resources do not exceed the medically needy resource standard ($2,500), but whose available income exceeds the cost of

care in the facility, are eligible for MA if the child's total medical expenses are greater than the amount by which the child's income exceeds the cost of care. These cases trickle from T02, due to being resource-eligible but income over-scale. Like T02, the T99 coverage group uses the FAC rules for consideration of income and resources. T99 is similar to L99, which trickles from L98 for the same reasons. MA will not pay for the cost of care in the LTCF because the recipient's available income covers the costs. However, MA will cover other medical services for which the recipient is eligible.

II. CARES Procedures Followed by MA Case Managers for MA Eligibility Determinations in the T-Track

The MA case manager should screen an applicant in the coverage group for which the applicant is most likely to qualify and which best fits the applicant's circumstances. For example:

- If the recipient is 18-20 years old, the recipient should be screened in T02 which goes up to 21 years old rather than in T05 which goes up to 19 years old.
- If the applicant has countable resources exceeding the medically needy resource standard of $2,500 for T02, the applicant should be screened in T03-T05, depending on the applicant's age. Resources are not considered for T03-T05.
- If an A/R is determined ineligible for one T-track coverage group and either CARES does not trickle or trickles incorrectly, the MA case manager should Add-A-Program to re-screen the A/R in other coverage groups for which the A/R may qualify in the T or L track. The CARES denial/closure notice should be suppressed by the MA case manager, unless it is determined that the A/R is not eligible for any other LTC coverage group.

AU Screened in T01

A T01 assistance unit (AU) consists of a child or adult who at admission to a LTCF is actively receiving TCA benefits and so is MA community-eligible in F01. MA will pay the facility's cost of care while the child or adult remains eligible for TCA.

- When the case manager adds a program to the existing F01 AU, CARES will not display a T01 coverage group on the "INCH" screen. Therefore, the case manager must call it up. In order to process correctly a T01 AU:
  - The Living Arrangement for this recipient must be coded as "TL" (Temporary LTC Admission) on the customer's "DEM1" screen for both the F01 and T01 AUs.
  - All members of the recipient's F01 AU must be coded on the "STAT" screen as a "NM" (Non-Member) for the recipient's T01 AU.
  - The recipient must be changed on the "STAT" screen to a "NM" of the F01 AU, which should trigger an unscheduled redetermination for the F01 AU.
- As long as the family remains eligible for TCA (and so is MA eligible as F01), the LTC recipient should remain eligible in T01, unless the recipient ages out of TCA. Then, the recipient's LTC eligibility should be redetermined for the most appropriate coverage group.

AU Screened in T02

This MA coverage group is for an unmarried child under age 21 residing in a LTCF, whose countable resources do not exceed the medically needy standard for a household of one person ($2,500) and whose countable net income is insufficient to pay the LTC cost of care.

- If the child's resources are within standard and the income is within standard (less than the LTC cost-of-care), the case is eligible for T02 and certified for 12 months, as long as the child's age is under 21.
- If the child is ineligible for T02 because the child's resources are within standard but the income is in excess of the standard (LTC cost-of-care), the case trickles to T99 (spenddown) in a preserved "M" status. As with other MA coverage groups, CARES also evaluates the income. For only the T-track, CARES actually changes the MA coverage group from T02 to T99, indicates that the AU is in spenddown, and gives the AU Status Reason Code of "401" to deny for over-scale resources. Therefore, the case manager should add the reason of "301" for over-scale income to the denial/closure notice that CARES generates for T02. CARES denies/closes MA eligibility for a case trickling to T99, and does not allow the worker to update the medical expense screens to authorize a spenddown.
- If the child is ineligible for T02 because the child's resources are over-scale and the income is in excess of the standard (LTC cost-of-care), CARES denies/closes due to over-scale resources (not also due to over-scale income). Therefore, the case manager should add the reason of "301" for over-scale income to the denial/closure notice that CARES generates.
- If the child is ineligible for T02 because the child's resources are over-scale but the income is within standard for T02, CARES may trickle the T02 AU to T03-T05 depending on the child's age. If not, the MA case manager should Add-A-Program to determine eligibility for T03-T05.

AU Screened in T03

For a child under age 1:

- If the income is within 185% FPL, the T03 AU is eligible and certified for 12 months.
- If the child is ineligible for T03 because the child's income is over 185% FPL, but the child's income does not exceed the cost-of-care and the child's resources are within the T02 standard, the case manager should Add-A-Program to determine the child's eligibility for T02.
- If the child is ineligible for T03 because the child's income is over 185% FPL, but the child's income is greater than the cost-of-care and the child's resources are within the T02 standard, CARES will apply the T02 cost-of-care rules and the AU will go into spenddown (T99). Since CARES gives the AU Status Reason Code as only "401" to deny for over-scale resources, the case manager should add the reason of "301" for over-scale income to the notice that CARES generates. CARES denies/closes the eligibility and does not allow the worker to update the medical expense screens to authorize a spenddown.
- If the child is ineligible for T03 because the child's income is over 185% FPL, but the child's income is greater than the cost-of-care and the child's resources are also over-scale for the T02 standard, CARES denies/closes due to over-scale resources (Code 401). In

the denial notice that CARES generates, the case manager should also add the reason of "301" for over-scale income.

AU Screened in T04

For a child who is over the age of 12 months but under 6 years old:

- If the income is within 133% FPL, the T04 AU is eligible and certified for 12 months.
- If the child is ineligible for T04 because the child's income is over 133% FPL, but the child's income does not exceed the cost-of-care and the child's resources are within the T02 standard, the case manager should Add-A-Program to determine the child's eligibility for T02.
- If the child is ineligible for T04 because the child's income is over 133% FPL, but the child's income is greater than the cost-of-care and the child's resources are within the T02 standard, CARES will apply the T02 cost-of-care rules and the AU will go into spenddown (T99).
- If the child is ineligible for T04 because the child's income is over 133% FPL, but the child's income is greater than the cost-of-care and the child's resources are also over-scale for the T02 standard, CARES denies/closes due to over-scale resources (Code 401). In the denial notice that CARES generates, the case manager should also add the reason of "301" for over-scale income.

AU Screened in T05

For a child who is under age 19 but at least 6 years old:

- If the income is within 100% FPL, the T05 AU is eligible and certified for 12 months.
- If the child is ineligible for T05 because the child's income is over 100% FPL, but the child's income does not exceed the cost-of-care and the child's resources are within the T02 standard, the case manager should Add-A-Program to determine the child's eligibility for T02.
- If the child is ineligible for T05 because the child's income is over 100% FPL, but the child's income is greater than the cost-of-care and the child's resources are within the T02 standard, CARES will apply the T02 cost-of-care rules and the AU will go into spenddown (T99).
- If the child is ineligible for T05 because the child's income is over 100% FPL, but the child's income is greater than the cost-of-care and the child's resources are also over-scale for the T02 standard, CARES denies/closes due to over-scale resources (Code 401). In the denial notice that CARES generates, the case manager should also add the reason of "301" for over-scale income.

III. Post-Eligibility Activity

T01 Who Loses TCA Eligibility

- When a T01 recipient ages out of TCA eligibility, the recipient's LTC eligibility must be redetermined. If the recipient is unmarried and under 21 years old, the recipient's

eligibility should be redetermined for T02. Otherwise, the recipient's LTC eligibility should be redetermined under the ABD rules for L98.

- If the F01 AU of a T01 child reports a change in countable resources to exceed the TCA categorically needy limit, both AUs will close down (closure reason "401"). CARES will not trickle. Before closing the T01 AU, the case manager should Add-A-Program to redetermine eligibility in the T03-T05 coverage group, as appropriate based on the child's age. The T03-T05 coverage groups do not have a resource test.
- If the T01 recipient is an adult whose F01 AU loses TCA eligibility due to over-scale resources, the recipient should be given the opportunity to reduce resources in order to retain MA LTC eligibility (as discussed in the Medical Assistance Eligibility Manual on pages 1000-47 – 1000-50) in the L98 coverage group. If resources are not promptly reduced, the T01 case should be closed with proper notice.
- If the F01 AU of a T01 recipient loses TCA eligibility due to over-scale income or another reason, CARES closes both the F01 and T01 AUs. Before closing the T01 AU, the case manager should Add-A-Program to redetermine eligibility in a T02-T05 coverage group, as appropriate. Also, the T01 recipient should be removed as a non-member of the F-track AU, so the active T-track recipient will not cause dual participation for the F-track AU.

T02 Who Becomes Resource-Ineligible

- If the child's resources become over-scale for T02 but the income remains within standard for T03-T05 depending on the child's age, CARES will trickle the AU to appropriate T-track coverage group with respect to the child's age. If the trickling does not occur properly, the MA case manager should Add-A-Program to determine eligibility in the most appropriate coverage group.

T03-T05 Who Becomes Income-Ineligible

- If the resources remain within standard for T02 and the income becomes over-scale for T03-T05 (based on the child's age) but does not exceed the LTCF's cost-of-care, the case manager should Add-A-Program to determine the child's eligibility for T02.

Child Who Ages Out of Coverage Group or No Longer Qualifies Due to Marriage

- For a child in T03-T05, the case manager should set an alert to trigger an unscheduled redetermination at least 90 days before the child reaches the age limit for the coverage group. The T03 should be tested for T04, the T04 should be tested for T05, and the T05 should be tested for T02. If the child being tested for T04 or T05 has resources that are within the T02 standard and the income is over the standard for T04 or T05 (based on the child's age) but does not exceed the LTCF's cost-of-care, the case manager should Add-A-Program to determine the child's eligibility for T02.
- If the child who is aging out of T05 is married, the case manager must redetermine eligibility under the ABD rules for L98.
- When a child in T02 becomes 20 years old, the case manager should set an alert to trigger an unscheduled redetermination at least 90 days before the child reaches 21 years old. The recipient's LTC eligibility should be redetermined under the ABD rules for L98.

- When a child in T02 gets married, the case manager must redetermine eligibility under the ABD rules for L98.

Unscheduled Redetermination When Recipient Is Discharged from LTCF

- When a T-track recipient is discharged from a LTCF, an unscheduled redetermination is required. MA eligibility may not be terminated until it is determined that the recipient is not eligible for community MA or MCHP.
- The redetermination procedures for a child discharged from a LTCF are similar to the specific procedures discussed in Policy Alert 10-9, Redetermination Procedures for Children Under the Age of 21 Being Discharged from IMDs, RICAs, or RTCs.
- For adults discharged to the community, the policies and procedures are addressed on pages 1000-55 and 1000-56 of the Medical Assistance Eligibility Manual.
- The LDSS must promptly trigger a redetermination of the recipient's eligibility for whatever coverage group fits the recipient's new circumstances.
  - If the recipient returns to an active TCA household, the LDSS determines if the recipient should be added to the existing TCA AU, and so would become MA eligible in the F01 coverage group.
  - If the recipient's community household is not eligible for TCA or the F-track, a child's eligibility may be determined in the P-track and an adult's eligibility may be determined in the S-track.
  - If a child is discharged into State-sponsored foster care or subsidized adoption, eligibility is determined in the E-track.
  - If the recipient is discharged into a home and community-based services waiver, eligibility is determined by the Division of Eligibility Waiver Services in the H-track.

NOTE: ALL CASE ACTIVITIES MUST BE FULLY NARRATED IN CARES.

Please direct questions concerning this Policy Alert to the DHMH Division of Eligibility Services at 410-767-1463. If you need assistance with CARES processing for these cases, you may contact Cathy Croghan-Sturgill at 410-238-1247.

case-by-case basis.

Age – A birth certificate is only one of the acceptable methods for establishing date of birth. There are a number of other methods such as insurance policies or baptismal, confirmation, marriage, Social Security, employment, school, or military service records. However, when an age limit is reached within the calendar year, the A/R must also provide proof of the actual month of birth.

The Department of Juvenile Services representative for a child who is an applicant for Medical Assistance is not required to provide verification of the child's age. It may be presumed that the child is under 21 years of age based on the child's commitment to the DJS.

Earned income for persons, other than the self-employed, must be verified by pay stubs or a complete written, signed and dated statement from the employer showing weekly, biweekly, etc., gross earnings for at least the last month or 4 weeks (more if necessary when income varies). Either is acceptable. A self-employed person must provide acceptable records of gross earnings and expenses and/or a copy of the most recent valid tax return.

Life Insurance – When the applicant has life insurance with a cash value, a statement must be obtained from the insurance company on company letterhead paper that verifies all necessary information-- current cash surrender value, policy number, policy owner. For the applicant's initial eligibility determination, however, the ET may use the current cash value from an amortization table in the life insurance policy, if the policy has a table reflecting the estimated current value. Then, verification of the actual current cash value by the insurance company is required no later than the first redetermination of eligibility.

If mail to the insurance company is undeliverable and there is no way to contact the company, the Maryland Insurance Commission should be contacted to help locate the company or its successor. If the company cannot be found, any information available on the cash value of the life insurance may be used. If no information can be obtained on the cash value, the life insurance is excluded as a resource. If the A/R makes a good faith effort to obtain information on the cash value, the eligibility determination is not delayed or denied due to the inability to determine the current cash value of life insurance.

Representative - Since the Medical Assistance program does not require a representative to be legally authorized by a court in order to act on the applicant's behalf, it is not necessary to obtain verification of guardianship or Power of Attorney. Signatures on the Medical Assistance application are sufficient to authorize a representative acting on the applicant's behalf.

Declaration of Information If Confirmed Impediment to Timely Verification

At times, an application for Medical Assistance is filed and verification of a specific factor of eligibility cannot be promptly produced for reasons beyond the applicant's control. When neither the applicant nor the representative can obtain a specific required verification within 45 days after the date of application, the worker should determine whether an eligibility decision is possible based on the information and verifications provided to date and

a written declaration by the applicant or representative of the facts related to the factor of eligibility that has not yet been verified. An eligibility decision using this declaration for a factor of eligibility means that information provided by the applicant or representative may be considered as having temporarily met verification requirements if the MA case manager determines that the applicant/representative has satisfactorily demonstrated and documented in writing that **all** of the following conditions exist:

- The applicant/representative made a "good faith effort" to obtain the required verification in a timely manner;
- The required verification cannot be obtained within 45 days for reasons beyond the control of the applicant/representative, and there is no other way to verify the specific factor of eligibility;
- The applicant/representative has provided information that he/she believes to be accurate;
- There is no other existing information that leads the MA case manager to believe that the statement of the applicant/representative is inaccurate or incomplete; and
- The applicant/representative agrees to produce the required verification no later than the next scheduled redetermination.

When **all** of these conditions are met, the worker may base the eligibility determination on the applicant/representative's written declaration of the facts related to that factor of eligibility.

Example 1

An application is filed on 1/1/04 on behalf of Ms. Smith. Ms. Smith's daughter, Claudia, is representing her mother in the application process. Ms. Smith is in a nursing home due to a stroke, which has left her unable to communicate. Prior to her stroke, Ms. Smith handled her own affairs and did not appoint a durable P.O.A. Ms. Smith has two bank accounts. Claudia's name is on one account. Therefore, she is able to obtain verification of the balance from the bank. The second account was with Shady Savings & Loan, that merged 6 months ago with another financial institution, RCG Bank & Trust. Claudia has a 10-month old statement from Shady Savings & Loan showing a $600 balance, but has no account number or documentation from the new institution. She has contacted the new institution, but they refuse to release any information to someone without a P.O.A or guardianship. Claudia states that the account does not exceed $650 as of the month of application. On 1/25/04, Claudia presents the following documents to the MA case manager:

- A copy of her letter to RCG Bank & Trust, requesting the 1/1/04 balance from Shady account #12345.
- A letter from RCG Bank & Trust, stating that records cannot be researched based on this information, and that the account information may only be released to the account holder, P.O.A., or guardian.
- A letter from an attorney agreeing to represent Claudia in a guardianship case, but advising that this process will take 3 to 6 months to complete.
- The Shady Savings & Loan bank statement from February 2003 showing a $602 balance.
- A letter signed by Claudia, explaining her unsuccessful efforts to obtain a current statement, stating that she believes the RCG & Trust account does not exceed $650, and agreeing to submit verification of the 1/1/04 account balance and current balance as soon as she gains guardianship and obtains the information from Shady Savings & Loan.

In this case, the worker considers the $650 as a countable resource, which together with the other assets totals $1,657. All other factors of eligibility are met. The case is narrated with regard to the outstanding verification, and Ms. Smith's eligibility is approved. No later than the first annual redetermination, the MA case manager must obtain verification from Claudia of the account balance for the month of application, as well as current month. If not received by the first annual redetermination, the case will be closed for failure to submit the required verifications.

Example 2
Mr. Cheetum is confined to a nursing home and is represented by his P.O.A., Mr. J. Jones, Esq. Mr. Jones provides bank balances as of the month of application, but states his client's assets prior to the last month are unknown, and that his client is in no condition to assist in the verification process. Since Mr. Jones was retained as P.O.A prior to his client's incapacitation, it is reasonable to assume that Mr. Cheetum discussed his financial affairs with his attorney at that time. It is incumbent upon Mr. Jones to review records and request information to establish Mr. Cheetum's assets over the look-back period (36 months). Although this process may take longer than the timeliness standard, a decision of eligibility cannot be made because Mr. Jones states he cannot provide a written statement concerning his belief as to the value and disposition of his client's assets during the look-back period. Mr. Jones may request an extension of time limits. If he does not, the application may be denied for failure to submit verifications, and will be reactivated if Mr. Jones provides the verifications before the end of the period under consideration.

Note: Maryland is not changing its eligibility policy to permit presumptive eligibility or declaratory applications. All factors of MA eligibility must still be verified either by the applicant/representative or by the MA case manager. However, the verification requirements must be reasonable. Allowance must be given for unusual situations when the applicant/representative is making a "good faith effort" but, due to a confirmed impediment outside his/her control, is unable to obtain the required verification within 45 days.

- It is not acceptable for an application to remain pending indefinitely without an eligibility decision. The application should be denied if the applicant/representative does not provide the required verifications by the due date, even if all of the conditions specified above are met, and the MA case manager either does not have enough information to determine eligibility, or the information that the MA case manager has received is questionable or contradictory.
- If the MA case manager has enough information to be able to clearly ascertain the facts of the case, eligibility should be determined, even if a specific verification cannot be obtained until later.
- Eligibility is not guaranteed. If a verification subsequently shows that the recipient is ineligible, the MA case manager should promptly conduct an unscheduled redetermination for this change in information.
- Existing policy relating to the extension of time limits may also be applied. However, such extensions should not be utilized routinely and repeatedly to delay eligibility determinations beyond 45 days from the date of application.

- When the MA case manager permits declaration of the specific factor of eligibility, the MA case manager should set a "745" alert to follow-up at the first redetermination or at the time that the verification is expected to be available. If the applicant/representative has not provided the verification, the MA case manager should call or write with a reminder of the verification requirements. If the verification is not received by the first redetermination, MA eligibility should be terminated due to failure to provide verifications.

The following materials are unacceptable for medical documentation:

1. Bills
2. Nurses' notes
3. State Review Team (SRT) materials, including DHR 402B
4. Case record materials, including immigration documents.

2. Documentation of Disability

Coverage as X02 is only available to persons who would be eligible in a federal Medical Assistance category (FAC, MCHP, or ABD) but for the alien status. The applicant is only eligible if the emergency medical condition criterion is met as well as all other MA requirements in a federal MA category, except citizenship and SSN.

Therefore, if the alien is applying as ABD and is not aged (65 or older), a disability determination by SRT is necessary besides the emergency medical review. The local department should promptly make the SRT referral. The SRT decision should be made **before** the local department submits the paperwork to DHMH for review of the emergency medical condition. The SRT decision should be included by the local department with the request sent to DHMH for a medical review.

- If the disability being reviewed by SRT is not related to the emergency medical treatment, a DHR/FIA 402B must still be completed and submitted to SRT.
- If the condition that required the emergency treatment is the same as the disabling condition being reviewed by SRT, the record of the emergency treatment should satisfy the SRT's medical documentation requirements. The DHR/FIA 402B is not necessary. However, SRT must still receive the DHR/FIA 707 transmittal form with the emergency treatment documentation.

Documentation of Labor and Delivery Services

The applicant/representative must provide the LDSS with a copy of the Discharge Summary that is signed by her physician and also includes her name, admission and discharge date, and the course of her hospital stay.

Medical Eligibility Review Process

All services must be reviewed and approved by a medical professional within the DHMH Medical Care Programs before payment is made. Medicaid does not compensate for services that are not directly related to the injury or illness that caused the emergency. The

approval will authorize payment for only those services necessary for treatment and stabilization of the emergency medical condition, not the full range of services covered under the Medicaid plan.

The medical report for determining medical emergency must be sent to:

DHMH, Beneficiary Services Administration
201 West Preston Street, Room L-9
Baltimore, Maryland 21201

Revised 2/02

Please mark envelopes: "Alien Emergency Services".

The DES 401 should accompany each report. If the applicant requires an SRT disability determination, the SRT decision must also be included. The medical report will be evaluated by Program personnel to determine if the services received were for the treatment of an emergency medical condition. The local department will be notified of whether the services received meet that requirement.

NOTE: The medical eligibility review process does not apply to labor and delivery services. The LDSS will determine whether the woman meets the medical eligibility requirements based on the documentation of the labor and delivery services discussed above.

Certification of Eligibility for X02

If all eligibility requirements are met, certify on an OTO (one-time-only) basis the alien who has the incurred expense for the approved emergency service (including labor and delivery). Certify only for the month(s) in which the approved emergency service was received. The CARES process is specified on page 500-8g. If eligibility is being determined by a hospital outstation worker, the worker's LDSS supervisor must review the case and approve eligibility before the worker finalizes the X02 eligibility in CARES.

Denial of Eligibility for X02

Process in CARES the denial of an application for emergency medical services as specified on page 500-8g. Denial reasons relevant to X02 for the ET to include on the manual denial notice are:

- "The service provided was not emergency in nature"
- "Technically ineligible (non-federal)"

EMERGENCY SERVICES TO INELIGIBLE ALIENS

Date: _____

TO: Beneficiary Services Administration
Office of Operations & Eligibility
201 West Preston Street
Baltimore, MD 21201

FROM: Local Department _____
Medical Assistance Unit

Unit Address: _____

_____

_____

Case Worker's Name: _____

Telephone #: _____

SUBJECT: Determination of Emergency Services – Aliens

Case Name: _____

Case Number: _____

Date of MA Application: _____

I have checked and agree that the technical and financial information for the applicant has been reviewed and meets the MA requirements except for citizenship.
Caseworker Signature: _____
(Please sign your name)

The above-named applicant has submitted a Medical Assistance application for coverage of emergency services received from _____ (date) to _____ (date) at _____.

Federal category for which the applicant is eligible, but for his/her alien status:
☐ FAC ☐ MCHP ☐ Aged ☐ Disabled/Blind

A copy of the following must be attached:

- ☐ MMIS screen 1 or MMIS/CARES screen showing results of search
- ☐ Discharge summary with admission and discharge dates
- ☐ ER admission
- ☐ Documentation showing the emergency nature of the medical services
- ☐ SRT determination (if qualifying as disabled/blind)

***Note: No bills or other extraneous information should be submitted.**

is filed with a court periodically to give an accounting of the trustee's handling of the trust. It will include the beginning value of assets, any income accrued, any disbursements made, and the current value. This report should be obtained in order to verify income countable to the A/R and current assets in the trust.

If the trustee is not required to file such a report, other documentation must be obtained to verify income, disbursements, and the current status of the trust. Records compiled by the trustee must be accompanied by supporting documents, such as bankbooks, cancelled checks, receipts, etc.

Evaluation of Trusts

A trust may represent a countable asset, a source of income, or a disposal subject to penalty. In order to properly evaluate a trust, many factors must be taken into consideration.

The first factor to consider is whether the trust is a countable resource. (See pages 800-1 - 800-3 of this chapter and the definition of "Resources" in COMAR 10.09.24.02.) Ownership of the trust must be determined and whether the trust's funds are accessible to the owner. A trust may only be counted as a resource for an applicant/recipient (A/R) if it meets the definition of a "resource", because it is accessible to the A/R or the A/R's spouse as the owner. Creation of a trust or other activity related to a trust during the past 60 months (e.g., change of ownership, change from being inaccessible to accessible, addition or reduction of assets in the trust) must be investigated.

Next, if the trust is not accessible to the A/R or the A/R's spouse, it must be determined whether the trust should be considered as a disposal subject to penalty based on whose money went into the trust. If the A/R's or spouse's money went into an inaccessible trust, a penalty

period may need to be imposed. Take special note of how to review a trust for determining whether a penalty period is applicable.

The rules for treatment of trusts established on or before August 10, 1993 differ from rules for trusts established after that date. The following policies and procedures are based on the date the trust was established.

RULES FOR TREATMENT OF TRUSTS

Pre-OBRA '93

This section is applicable to trusts established on or before August 10, 1993. It does not apply to trusts established after that date. A trust established on or before August 10, 1993, but which is funded, added to, or otherwise augmented after that date is treated under the pre-OBRA rules. However, the funds placed in the trust after that date may be considered disposals. In all cases, the A/R must document when assets were placed in the trust. A trust is only treated in accordance with this policy if it meets the definition of a "resource", as being accessible to the A/R or to the A/R's spouse.

Medicaid Qualifying Trusts

The policies discussed below are based upon the Consolidated Omnibus Budget Reconciliation Act of 1985, HCFA Medicaid Letter 92-54, and Section 3215 of the State Medicaid Manual.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) amended section 1902 of the Social Security Act to provide that assets in certain trusts would be countable for the purpose of determining eligibility for Medical Assistance. These trusts are called "Medicaid Qualifying Trusts."

A payment from an exempted trust may be considered a disposal for less than fair market value if the goods or services received are not commensurate with the expenditure.

C. Special Needs Trusts (New requirements based on COMAR amendments effective 4/29/02)

As with any other trust, a special needs trust may only be considered as a resource for the applicant/recipient (A/R) if it meets the definition of a "resource", as being accessible to the A/R or the A/R's spouse. To be not countable as a resource, a Special Needs Trust established after August 10, 1993 must meet all of the following criteria below in 1. - 11. (as specified in COMAR 10.09.24.08-2C):

1. The trust is irrevocable. Any trust that may be revoked or altered does not meet this criterion and so is counted as a resource.

2. The trust states that the beneficiary is disabled under COMAR 10.09.24.05E. The beneficiary's disability must be confirmed by the Social Security Administration or by the State Review Team. If the beneficiary has not been determined disabled by SSA or SRT, the trust is counted as a resource.

3. The beneficiary of the trust is younger than 65 years old at the time the trust is established. If the beneficiary was 65 or older when the trust was established, it is counted as a resource.

4. The trust was established by the beneficiary's parent, grandparent, legal guardian or a court. If the trust was established by any other person, it is counted as a resource.

5. The trust does not contain provisions that conflict with the policies set forth in COMAR 10.09.24.08-2. This means the trust must limit distributions to those that are for the sole benefit of the beneficiary. Also, no provision of the trust may thwart the Department's recovery, upon the death of the beneficiary, of Medical Assistance benefits paid on behalf of the beneficiary. If the trust conflicts with these policies, it is counted as a resource.

6. The trust provides that the Department shall receive all amounts remaining in the trust upon the death of beneficiary, or upon termination of the trust for any other reason, up to an amount equal to the total Medical Assistance benefits paid on behalf of the beneficiary. If the trust does not provide for State recoveries, it is counted as a resource.

7. The trust does not permit distribution of trust assets upon termination of the trust that would hinder or delay reimbursement to the Department. Aside from distribution of administrative costs for termination of the trust, the Department must have first claim to the trust assets, up to the amount of Medical Assistance payments. If the trust permits distribution of its assets when it is terminated, it is counted as a resource.

8. The trust does not place time limits, or any other limits, on the Department's claim for reimbursement under COMAR 10.09.24.08-2C(8). If the trust places a limit on State recoveries, it is counted as a resource.

(9) The trust must contain all of the following provisions:

(a) Additions, including resources and income, may not be made to the trust after the beneficiary is 65 years old.

(b) Expenditures from the trust must be used for the sole benefit of the beneficiary and must be directly related to the beneficiary's health care, education, comfort, or support.

(c) The beneficiary may not serve as trustee or in any other capacity that would allow the beneficiary to influence or exercise authority or control over trust distributions.

(d) The trustee must administer the trust in accordance with all of the following provisions of Estates and Trust Article § 15-502, Annotated Code of Maryland:
(i) The trustee may not have an interest in the trust's assets.
(ii) The trustee may not have discretion to use trust assets for the trustee's own benefit.
(iii) The trustee may not self-deal by selling trust assets to the trustees or buying trust assets from the trustee.
(iv) The trustee may not loan trust assets to the trustee.

(e) The trustee must not take more compensation than is allowed in the provisions of Estates and Trusts Article, §14-103, Annotated Code of Maryland.

(f) Any leases or mortgages that the trust holds must contain a provision that they either terminate or become due and payable when the beneficiary dies or the trust is terminated.

(g) If the trust owns titled property that is valued at more than $500.00, the property must be titled to the trust, except for securities which may be held in the name of a nominee.

(h) If the trust owns an asset jointly with another, the ownership must be as tenants in common (see page 800-4), and the ownership agreement must provide that, when the trust is terminated, the property must be sold for fair market value or the other owners must purchase the trust's interest in the property for fair market value.

(i) Trust assets may not be held as an on-going business or enterprise, or as investments in new or untried enterprises.

(j) Trust distributions may not be used to supplement Medical Assistance payments to any health care provider serving the beneficiary. The provider is required to accept Medical Assistance reimbursement as payment in full for the services billed.

(k) Trust assets may not be used to compensate family members of the beneficiary for serving the beneficiary in any way, including:
(i) Caring for the beneficiary;

(ii) Accompanying the beneficiary on travel;

(iii) Providing companionship to the beneficiary ; or

(iv) Serving as trustees or on a trust advisory committee.

.03-1 Coverage Group for Women with Breast or Cervical Cancer– Purpose, Definitions, and Eligibility Criteria.

A. Purpose.

(1) The purpose of Regulations .03-1 and .03-2 of this chapter is to exercise the State's option under Title XIX of the Social Security Act to create a new Medical Assistance optional categorically needy coverage group for women who need treatment for breast cancer, cervical cancer, or pre-cancerous conditions, in accordance with the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354).

(2) Coverage under this regulation is subject to the availability of State and federal funds.

B. Definitions. In Regulations .03-1 and .03-2 of this chapter, the following terms have the meanings indicated.

(1) "Applicant" means an individual whose application for the Medical Assistance eligibility under the women's breast and cervical cancer coverage group has been submitted to the Department or its authorized representative, but has not received final action.

(2) "Application date" means the date on which a written, signed application for Medical Assistance eligibility under the women's breast and cervical cancer coverage group is received by the Department or its authorized representative.

(3) "Breast and Cervical Cancer Diagnosis and Treatment Program" means the State-funded program of cancer diagnosis and treatment services, which is:

(a) Governed by COMAR 10.14.02; and

(b) Administered by the Department's Center for Cancer Surveillance and Control.

(4) "Cancer treatment services" means active medical treatment for breast cancer, cervical cancer, or a pre-cancerous condition, not including palliative care.

(5) "Categorically needy coverage group" means a category of Medical Assistance eligibility defined at Regulation .03A of this chapter.

(6) "Creditable health insurance coverage" means having one or more of the following types of coverage:

(a) A group health plan;

(b) Health insurance coverage with medical care benefits provided directly or through insurance, reimbursement, or otherwise and including items and services paid for as medical care, under any:

(i) Hospital or medical service policy or certificate;

(ii) Hospital or medical service plan contract; or

(iii) Health maintenance organization contract offered by a health insurance issuer;

(c) Medicare Part A **or** Part B;

(d) Medical Assistance;

(e) Armed forces insurance; or

(f) A state health risk pool.

(7) "Enrollee" means a woman who is determined eligible and is receiving Medical Assistance benefits under Regulations .03-1 and .03-2 of this chapter.

(8) "Health professional" means a licensed physician or certified registered nurse practitioner.

(9) "Institutionalized person" has the meaning specified at Regulation .08B of this chapter.

(10) "Mandatory Medical Assistance categorically needy coverage group" means a Medical Assistance categorically needy coverage group which the federal government requires a state to cover under the State Plan, in accordance with the Code of Federal Regulations.

(11) "Maryland Breast and Cervical Cancer Screening Program" means the National Breast and Cervical Cancer Early Detection Program in Maryland which:

(a) Is funded by the State or federal government;

(b) Is administered by the Department's Center for Cancer Surveillance and Control through the local jurisdictions; and

(c) Has income and other eligibility requirements.

(12) "National Breast and Cervical Cancer Early Detection Program (NBCCEDP)" means the program of the Centers for Disease Control (CDC), established under Title XV of the Public Health Service Act.

(13) "Needs treatment" means that, according to a written certification by a health professional, the individual needs cancer treatment services, such as chemotherapy, radiation, or surgery.

(14) "Pre-cancerous condition" means for:

(a) Cervical cancer, a condition diagnosed as cervical intra-epithelial neoplasia I, II, or III; or

(b) Breast cancer, a condition diagnosed as atypical ductal hyperplasia